

SOUTH DAKOTA BOARD OF COUNSELOR EXAMINERS

APPLICATION FOR LICENSED PROFESSIONAL COUNSELOR (LPC) by **EXEMPTION** (ARSD 20:68:01:06)

NOTE The Board may grant a license by Exemption for Licensed Professional Counselor (LPC) pursuant to SDCL 36-32-13.2 to any applicant if the following requirements are met:

- (1) Has attained at least a master's degree in counseling or a related mental health field prior to January 1, 2008 and acceptable to the board as evidenced by an official educational transcript;
- (2) Submits three letters of verification on forms provided by the board documenting a minimum of ten years of at least half-time professional counseling as defined in **SDCL subdivision 36-32-1(5)*** in the immediate fifteen years preceding the date of the application; and
- (3) Completes an application by January 1, 2008 pursuant to §§ subdivisions 20:68:01:02 (1)(3)(5).

***SDCL 36-32-1(5):** "Practice of professional counseling," application of mental health, psychological, and human development principles in order to:

- (a) Facilitate human development and adjustment throughout the life span;
- (b) Prevent, diagnose, and treat mental, emotional, or behavioral disorders and associated distresses which interfere with mental health;
- (c) Conduct assessments and diagnoses for the purpose of establishing treatment goals and objectives; and
- (d) Plan, implement, and evaluate treatment plans using counseling treatment interventions;

Applications must be accompanied by a non-refundable license application fee of \$100. A personal check or money order should be made payable to the South Dakota Board of Counselor Examiners. A **photo** (no larger than 3 x 5) **must be submitted** for identification purposes.

I hereby make application for licensure to practice as a Licensed Professional Counselor in the State of South Dakota.

(Please type or print legibly.)

SECTION I. GENERAL INFORMATION

1. Name _____
Last First MI
2. Name as you wish it to appear on the license _____
3. Social Security No. _____ Date of Birth _____
4. Home Address _____

5. Business Address _____

6. Home Phone # _____ Business Phone # _____

7. I have / have not (CIRCLE ONE) made a previous application to South Dakota Board of Counselor Examiners. If yes, please state on a separate sheet of paper.
 8. I have / have not (CIRCLE ONE) ever been convicted of, pled guilty to, or pled no contest to, an offense that could have resulted in incarceration for more than a year. If yes, please explain on a separate sheet of paper.
 9. I have / have not (CIRCLE ONE) had a license denied, revoked, suspended, or otherwise acted against for any reason in another state, territory, or in South Dakota? If yes, please explain on a separate sheet of paper.
 10. I have / have not (CIRCLE ONE) been disciplined by a mental health licensing or certification board or by any mental health related professional organization? If yes, please explain on a separate sheet of paper.
 11. I am / am not (CIRCLE ONE) \$1,000 or more behind in child support payments.
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SECTION II. GRADUATE COUNSELING PROGRAM (ARSD 20:68:01:06)

12. List the institution(s) from which you have received graduate degrees in counseling. **A official transcript of your graduate degree must be sent directly to the Board's office by the institution awarding the degree.**

UNIVERSITY/COLLEGE _____

CITY/STATE _____

DEGREE & DATE GRANTED _____

DATES ATTENDED _____

MAJOR/SUBJECT _____

SECTION III. LETTERS OF VERIFICATION (ARSD 20:68:01:06(2))

See separate attachment/form.

Applicant must submit three letters of verification on forms provided by the board documenting a minimum of ten years of at least half-time professional counseling as defined in **SDCL subdivision 36-32-1(5)*** in the immediate fifteen years preceding the date of the application. To qualify for a License by Exemption the Applicant's practice must encompass all the facets of counseling as defined below.

*SDCL 36-32-1(5): "Practice of professional counseling," application of mental health, psychological, and human development principles in order to:

- (a) Facilitate human development and adjustment throughout the life span;
 - (b) Prevent, diagnose, and treat mental, emotional, or behavioral disorders and associated distresses which interfere with mental health;
 - (c) Conduct assessments and diagnoses for the purpose of establishing treatment goals and objectives; **and**
 - (d) Plan, implement, and evaluate treatment plans using counseling treatment interventions;
-

SECTION IV. AFFIDAVIT

I hereby state that I have fully read and understand the questions presented in this application and have answered them truthfully and completely. I acknowledge that my failure to make a full and accurate disclosure of any information called for herein may result in the denial of my application. I further acknowledge that any license I may obtain on the basis of this application may be revoked or suspended for my failure to disclose full and accurate information herein.

I will furnish additional information or documentation as may be deemed necessary by the South Dakota Board of Counselor Examiners for their verification of the information I have disclosed in this application.

I will not hold myself out as a state Licensed Professional Counselor until the license authorizing me to do so is in my possession.

I hereby declare under penalty of perjury that the foregoing answers and statements are true and correct.

STATE OF _____)
:SS
COUNTY OF _____)

The undersigned, being duly sworn deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every aspect; that he/she will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.

Dated this ____ day of _____, 200 ____.

Signature of Applicant

Sworn to before me this _____ day of _____, 200 ____.

NOTARY PUBLIC

My Commission expires:

(SEAL)

**SOUTH DAKOTA BOARD OF COUNSELOR EXAMINERS
LICENSE PROFESSIONAL COUNSELOR (LPC) by *EXEMPTION***

**LETTERS OF VERIFICATION OF PROFESSIONAL COUNSELING PRACTICE
(ARSD 20:68:01:06(2))**

*Please Submit A Separate Letter and Form for **each** Verification*

(Applicant completes this section)

APPLICANT'S NAME: _____
Last First MI

DATE: _____

The individual named above is applying for a license to practice counseling in the State of South Dakota. The South Dakota Board of Counselor Examiners (Licensing Board) requires verification of the following information which will enable the Board to evaluate the extent of the candidate's professional counseling practice.

I. I, the undersigned, verify _____ (applicant's name) has met all the following requirements as defined below:

A minimum of ten years of at least half-time professional counseling as defined in **SDCL subdivision 36-32-1(5)*** in the immediate fifteen years preceding the date of the application. The Applicant's practice must encompass all the facets of counseling as defined below.

***SDCL 36-32-1(5):** "Practice of professional counseling," application of mental health, psychological, and human development principles in order to:

- (a) Facilitate human development and adjustment throughout the life span;
- (b) Prevent, diagnose, and treat mental, emotional, or behavioral disorders and associated distresses which interfere with mental health;
- (c) Conduct assessments and diagnoses for the purpose of establishing treatment goals and objectives; and
- (d) Plan, implement, and evaluate treatment plans using counseling treatment interventions;

II. On a separate typed sheet, please define your relationship with the Applicant, including length of relationship, whereby you have this knowledge of the Applicant's professional counseling practice.

III. Your type of professional license / certification? _____

(continued, over)

ATTESTATION (Please sign before a Notary Public)

I attest to the fact the information I have provided is true and accurate, and that I will respond to the Board of Counselor Examiners should questions arise.

Signature

Date

Print Name

Phone Number

City ST Zip

STATE OF _____)

:SS

COUNTY OF _____)

The above signed, being duly sworn deposes and says that he/she is the person who executed this application; that the statements herein contained are true in every aspect; that he/she will conform to the ethical standards of conduct in his/her profession; and that he/she has read and understands this affidavit.

Dated this ____ day of _____, 20 ____.

Sworn to before me this _____ day of _____, 20 ____.

NOTARY PUBLIC

My Commission expires:

(SEAL)

Please return completed form to:

SD Board of Counselor Examiners, PO Box 1822, Sioux Falls, SD 57101-1822